

with the standard five years of tamoxifen treatment, with additional costs per QALY gained.

## PCN16

**ADDING RITUXIMAB TO STANDARD CHEMOTHERAPY APPEARS DOMINANT VS. CHEMOTHERAPY ALONE IN ADVANCED STAGE NHL—INTERIM RESULTS FROM A RANDOMIZED CLINICAL TRIAL (RCT)**

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**OBJECTIVES:** To identify cost consequences and cost effectiveness of R-MCP (rituximab, mitoxantrone, chlorambucil, prednisolone) vs. MCP from the perspective of a third party payer in Germany (statutory sickness fund). **METHODS:** Resource utilization data on 329 patients were collected in parallel to a RCT and analyzed for the treatment phase (8 months). In addition, an interim analysis of the subsequent observation period was conducted. Data for initial chemotherapy, chemotherapy administration, treatment of adverse events, treatment of complications/progressive disease, subsequent chemotherapies, and treatment for other reasons were collected. Several sensitivity analyses were performed to address different cost environments and discounting scenarios. **RESULTS:** Mean cost of the treatment phase in the base case analysis was €35,600 for R-MCP and €21,500 MCP per patient ( $p < 0.0001$ ). More treatment cycles were administered in the R-MCP arm (1026 MCP, 1237 R-MCP). Mean cost per patient and active treatment cycle was €4900 for R-MCP and €3300 for MCP ( $p < 0.0002$ ). Mean observation period after end of initial treatment were 26.9 months for R-MCP and 25.8 months for MCP. Costs for treatment of adverse events, new chemotherapies, treatment of progressive disease and other reasons was substantially reduced in the R-MCP arm. This resulted in mean (undiscounted) cost per patient in the observation period of €17,900 for R-MCP and €30,700 for MCP ( $p < 0.01$ ). Overall costs were €51,100 for R-MCP and €53,900 for MCP ( $p = 0.6$ ). Clinically, R-MCP resulted in statistically significant superior response rate, event free survival and overall survival. **CONCLUSION:** Initially higher treatment costs of R-MCP were compensated by savings due to reduced toxicity and better efficacy after slightly more than two years. Combined with the clinical superiority of R-MCP, this regime is likely to prevail as the dominant treatment strategy compared to MCP alone at the final analysis (at four years observation).

## PCN17

**THE COST-EFFECTIVENESS OF CETUXIMAB IN COMBINATION WITH IRINOTECAN FOR THE TREATMENT OF PATIENTS WITH EGFR-EXPRESSING METASTATIC COLORECTAL CANCER AFTER FAILURE OF IRINOTECAN-INCLUDING CYTOTOXIC THERAPY IN SCOTLAND**

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**OBJECTIVES:** Cetuximab in combination with irinotecan (cet/iri) is a new chemotherapy option for patients with EGFR-expressing metastatic colorectal cancer after failure of irinotecan-including cytotoxic therapy. In Scotland, the prognosis for patients with metastatic colorectal cancer (mCRC) is poor and there are limited therapy options after the failure of conventional cytotoxic agents. Our objective was to determine the incremental cost-effectiveness of cet/iri compared to current practice in Scotland. **METHODS:** Given there are no licensed treatment

options for this patient group in Scotland, the economic evaluation compared cet/iri with best/active supportive care (ASC). The perspective of the economic evaluation was that of the National Health Service in Scotland. The economic evaluation was based on a pivotal clinical trial comparing cetuximab in combination with irinotecan with cetuximab monotherapy (BOND). As the BOND study did not directly compare cet/iri with ASC, the data were 'bridged' to estimate overall survival. Sensitivity analyses are presented by way of both probabilistic analysis and univariate sensitivity analysis. **RESULTS:** Data from the BOND study showed median time to disease progression (TTP) is significantly longer with cet/iri, 4.1 months, than cetuximab alone, 1.5 months. Median survival was 8.6 months for cet/iri and 6.9 months for cetuximab. In our evaluation, estimated mean overall survival was 10.8 months for cet/iri and 5.6 months for ASC. Over the duration of the economic model, cet/iri patients incurred additional costs of ≤13,851 and gained additional 0.42 life-years per patient compared with ASC patients. The incremental cost per life-year gained for cet/iri versus ASC was ≤32,752. The incremental cost per QALY gained was ≤34,454. **CONCLUSIONS:** Cet/iri is an effective chemotherapy option for mCRC patients failing conventional cytotoxic agents and who have limited therapy options. Our study shows that cet/iri is also within the range of acceptable cost-effectiveness when compared to other oncology therapies.

## PCN18

**LETROZOLE (FEMARA) IS A COST-EFFECTIVE TREATMENT IN THE EXTENDED ADJUVANT SETTING IN WOMEN WITH EARLY BREAST CANCER: AN APPLICATION TO CANADA**

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**OBJECTIVES:** Although tamoxifen shows benefit in the first five years of adjuvant therapy, extending its use by an additional five years is not beneficial. This has created an unmet medical need for patients who are disease free after 5 years of standard adjuvant therapy, but still have a significant risk of relapse over the following ten years. In a large randomized placebo-controlled trial, letrozole significantly reduced the risk of recurrence by 42% and the risk of distant metastases by 39%. The DFS was significantly improved with letrozole regardless of nodal status. **METHODS:** A Markov model was developed to evaluate the lifetime cost-utility of extended adjuvant letrozole in postmenopausal women. The cost-utility analysis was based on the results of the MA17 trial, from which patient-level data was used to estimate event rates in both treatment groups. Expected costs, life-years and QALYs were estimated by summing across all health states and cycles for each treatment group. Deterministic and probabilistic sensitivity analyses were performed to account for uncertainty. **RESULTS:** The baseline results from the model show ICERs of \$30,100/LY and \$34,058/QALY for a cohort of 1000 postmenopausal women. Letrozole is even more cost-effective in the node positive patient sub-group than for the aggregate patient group, with an incremental cost per life-year of \$23,235 and an incremental cost per QALY of \$26,553. For node negative patients the model shows ICERs of \$41,357 per life-year and an incremental cost per QALY of \$46,049. The sensitivity analyses show narrow ranges for the credible intervals, and for a threshold of \$50,000/QALY the likelihood that letrozole would be cost-effective is 1.0 in node positive patients, while being 0.77 in node negative patients. **CONCLUSION:** Our model shows that letrozole is cost-effective in both node negative and node positive patients with ICERs far below the generally accepted threshold of \$50,000/QALY.